HARFORD COUNTY LOCAL CARE TEAM REFERRAL

Referral Received:_____

LCT Scheduled:_____

Name of Child _____
Please Print (Last) (First) (Middle)

Address: _____
(Street) (Town) (State) (Zip Code)

Gender_____ Race_____ Ethnicity_____ Religion_____ Birth date_____

Parent/Guardian Name(s):_____

Parent/Guardian Phone: Home: _____ Work: _____ Cell: _____

Parent/Guardian Address: _____

Child's Medical Insurance _____ (primary)

_____ (secondary)

Referring Agency or Person_____ Telephone:_____

1. Describe why you are seeking services: _____

_____

_____

_____

_____

2. When did the problem begin? _____

3. Is there any involvement with:

Division of Rehabilitation Services	Yes □	No □	
Department of Social Services	Yes □	No □	
Department of Juvenile Justice	Yes □	No □	*Probation* □ *Intake* □
Developmental Disabilities Administration	Yes □	No □	
Family Navigator	Yes □	No □	

If yes, Worker's Name(s)_____ Telephone:_____

Reason for Services: _____

4. Name of School: _____ Grade: _____

Has the child received any Special Education Services? Yes □ No □ *504 Plan* □ *IEP* □

If yes, what services? _____

5. Child's Current Treating Mental Health and/or Substance Abuse Provider(s) & Telephone Number(s):

_____

6. Child's Current Medical Diagnoses_____

   Mental Health Diagnoses_____

7. Is the child currently prescribed any medications? Yes □ No □

   If so, please list: _____

   Is the child currently compliant with his/her medications? Yes □ No □

8. Has the child ever received counseling or outpatient treatment in the past? Yes □ No □

   If yes, when and where?_____

   _____

   Number of years of active mental health treatment _____

9. Has the child ever received residential treatment before? Yes □ No □

   If yes, when and where? _____

10. Has the child ever had a psychiatric hospitalization before? Yes □ No □

    If yes, when and where? _____

    Number of E.R. visits or other Crisis Episodes last 12 months _____

11. Has the child ever planned for/tried to commit suicide? Yes □ No □

    If yes, when? _____

12. Has the child ever lived with a non-parent? Yes □ No □

    If yes, when and with whom? _____

13. Is Child Adopted? Yes □ No □ If yes, at what age?_____

14. Is drug or alcohol abuse suspected currently? Yes □ No □

    If yes, please explain. _____

    Current or prior addiction or substance abuse treatment _____

    _____

15. Dates of Previous Local Care Team or Local Coordinating Council Meeting(s): _____

16. List members of child's current household.

Name	Age	Relationship to Patient
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

17. Check any entitlements the child currently receives

□ SSI/SSDI □ Food Stamps (Family) □ Survivor's Benefits □ Other_____

18. Please list name and address/FAX of others you would like invited to the LCT meeting. Only list parties for whom the Sponsoring LCT Agency has written consent from the parent/guardian to invite.

Name	Mailing Address or FAX Number
_____	_____
_____	_____
_____	_____
_____	_____

19. Completed By _____Relationship_____Date_____

20. LCT Representative Signature _____Agency_____Date_____

(A Local Care Team meeting cannot be scheduled without the signature of the sponsoring agency's LCT representative which confirms that there is a need for a review by the Local Care Team and that the LCT representative has reviewed this Referral.)

When completed, please mail or FAX this Referral to:

Local Care Team
206 South Hays Street
Suite 201
Bel Air, Maryland 21014
FAX 410-803-8732
Attn: Meredith Miller

For questions related to the Local Care Team or this Referral form, please call Ms. Miller at 443-388-7266.

Please note:

It is the responsibility of the Local Care Team Representative to ensure that the following are brought to the scheduled LCT meeting: 10 copies of the LCT Referral Form and of any information which will be important for the Local Care Team to review (e.g. recent psychological or educational reports, IEP or 504 Plans, recent discharge summaries, letters of recommendation, recent service or treatment plans, etc).
Appropriate releases of information to the LCT as well as a 10-day Waiver (if needed) are also required to be held in the LCT case file; please bring one copy.